

# 2011 Military Health System Conference

## Behavioral Health in the Patient Centered Medical Home: Meeting the Quadruple Aim

### Part 1

*The Quadruple Aim: Working Together, Achieving Success*

*Charles C. Engel, MD, MPH, COL, MC, USA*

January 24, 2011



Director, Army RESPECT-Mil Program  
Associate Chair (Research), Department of Psychiatry  
Uniformed Services University School of Medicine  
Director, Deployment Health Clinical Center at Walter Reed  
Senior Scientist, Center for the Study of Traumatic Stress

[cengel@usuhs.mil](mailto:cengel@usuhs.mil)

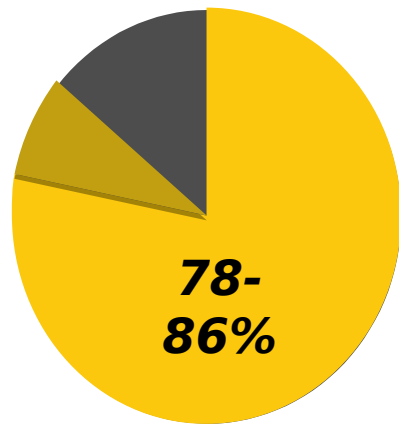
# *Why Primary Care?*

## A Gap Between Needs & Services

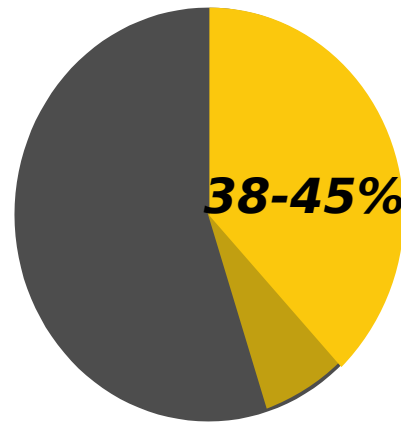
Among the 20% of Soldiers with moderate to severe disorder after OIF deployment...

*Got help (past 12 months)*

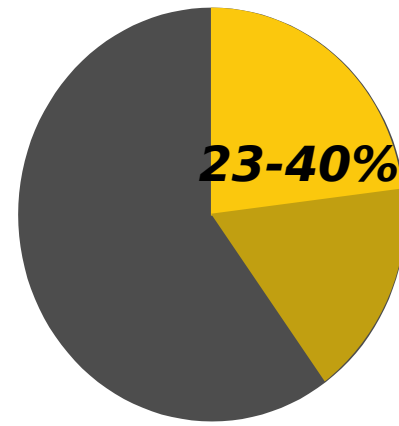
*Acknowledge a problem*



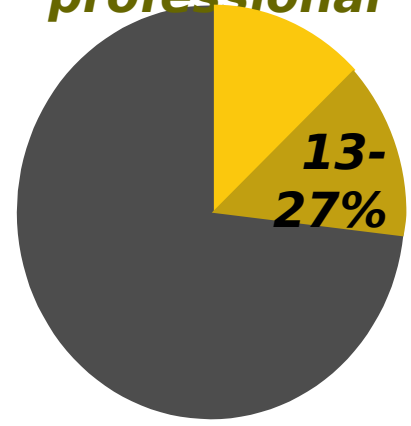
*Want help*



*Any professional*



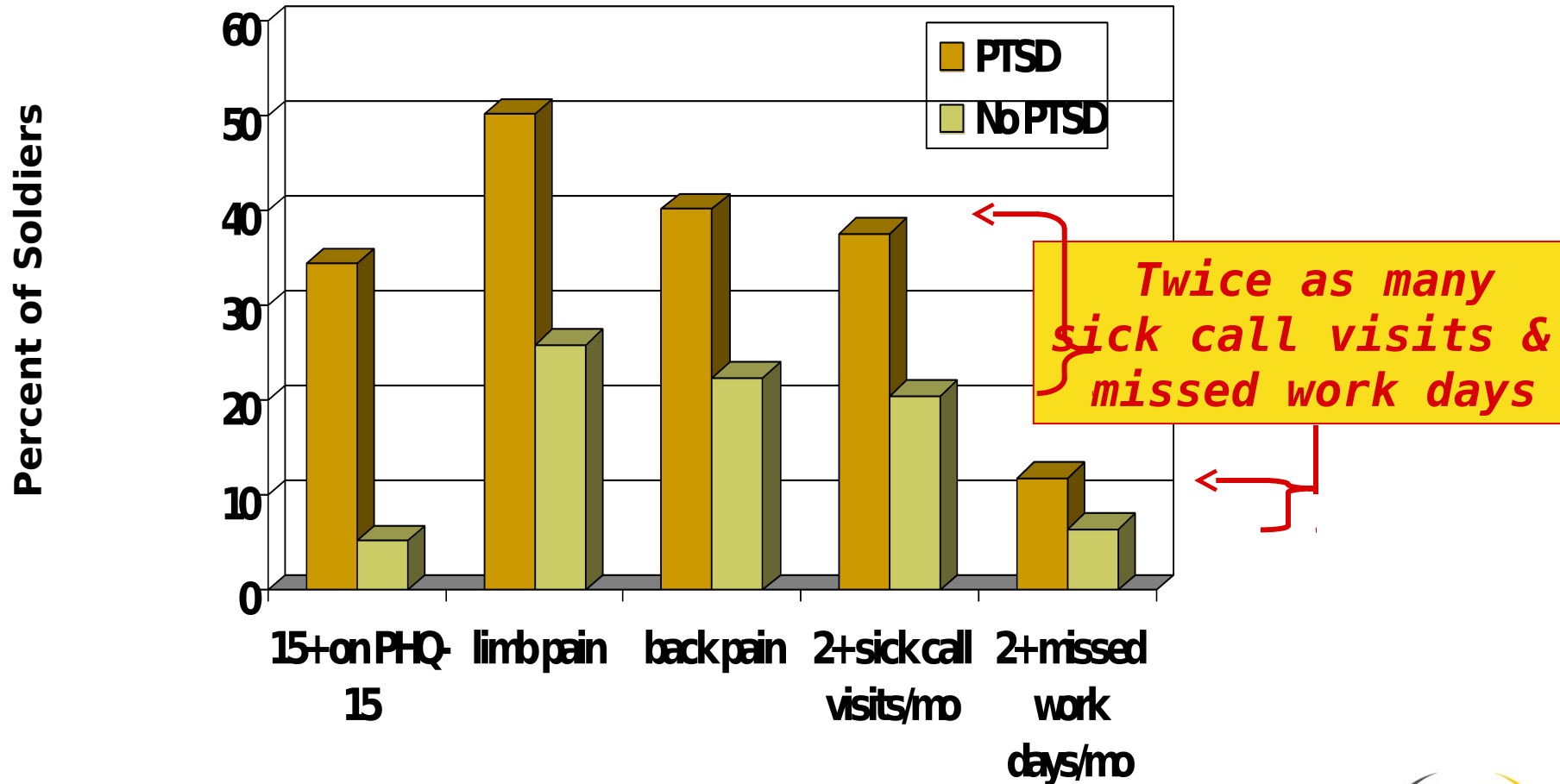
*Mental health professional*



Hoge CW, et al. *N Engl J Med.* 2004;351:13-22.

# Potential for Offset: Service Use & Missed Work

*2,863 Iraq War returnees one-year post-deployment*



# Primary Care...

## Where Soldiers Get Their Care



- Mean primary care use is 3.4 visits per year
- 88-94% have one or more visits per year
- Primary care approach to mental health is an opportunity to...
  - Reduce stigma & barriers
  - Intervene early
  - Reduce unmet needs
  - Reduce unnecessary service use

# Primary Care Intervention is Evidence-Based



Randomized trials offer sound evidence that systems-level approaches benefit...

- Depression (e.g., IMPACT Trial BMJ 2006)
- Suicidal ideation & depression (Bruce et al, JAMA 2004)
- Depression and physical illness (e.g., Lin et al, JAMA, 2003)
- PTSD and physical injury (Zatzick, AGP, 2004)
- Panic disorder (e.g., Roy-Byrne et al, AGP 2005)
- Somatic symptoms (e.g., Smith et al, AGP 1995)
- Health anxiety (e.g., Barsky et al, JAMA 2004)
- Substance dependence (e.g., O'Connor et al. Am J Med. 1998)
- Dementia (e.g., Callahan et al, JAMA 2006)

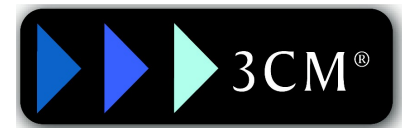
# *RESPECT-Mil*

*Engineering Systems of Primary Care Treatment in the Mi*

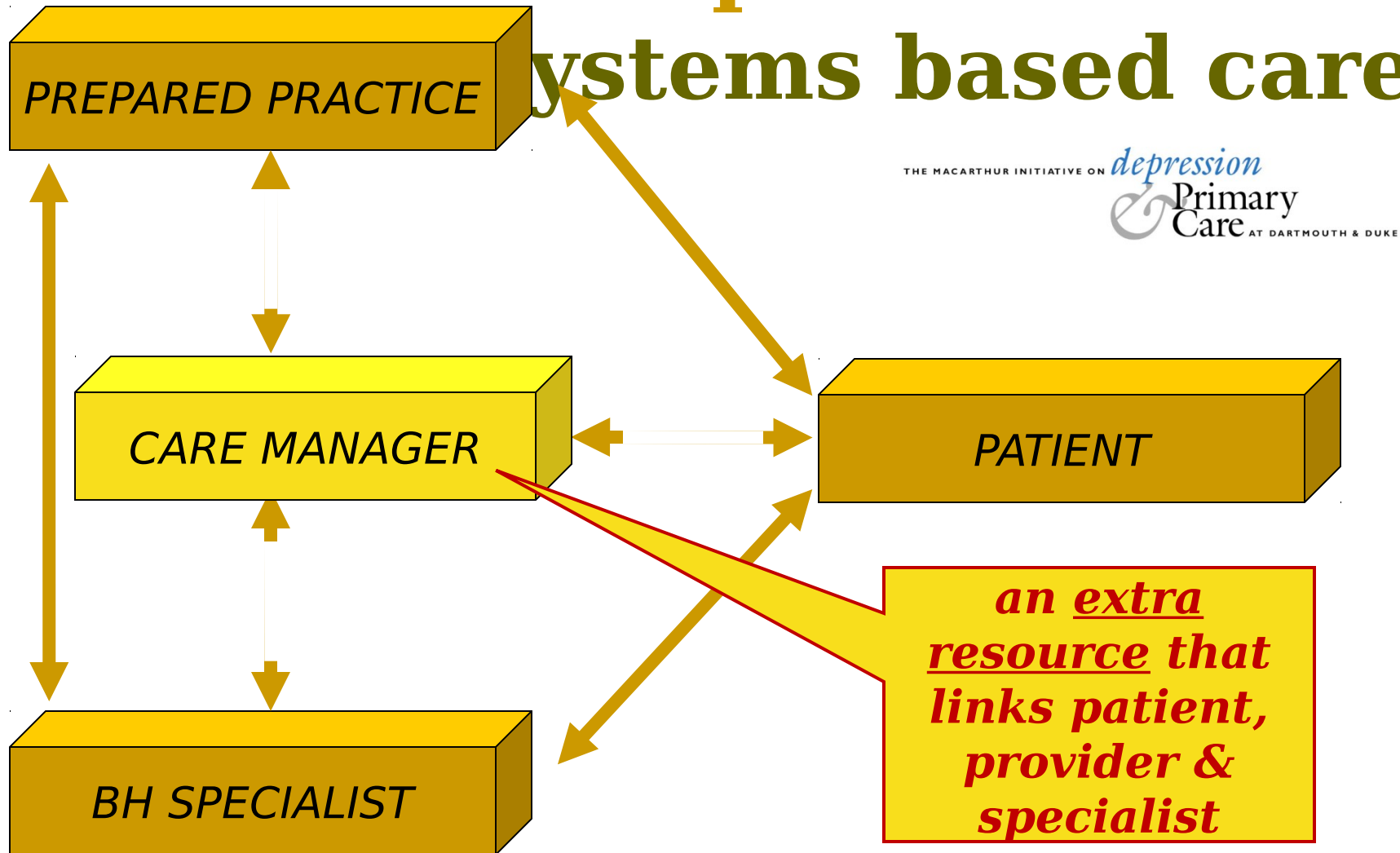
Defense Centers of Excellence for Psychological Health & TBI  
Office of The Surgeon General, Army  
Deployment Health Clinical Center  
Uniformed Services University  
3CM®

COLORADO SPRINGS, CO

5-7 OCTOBER 2010

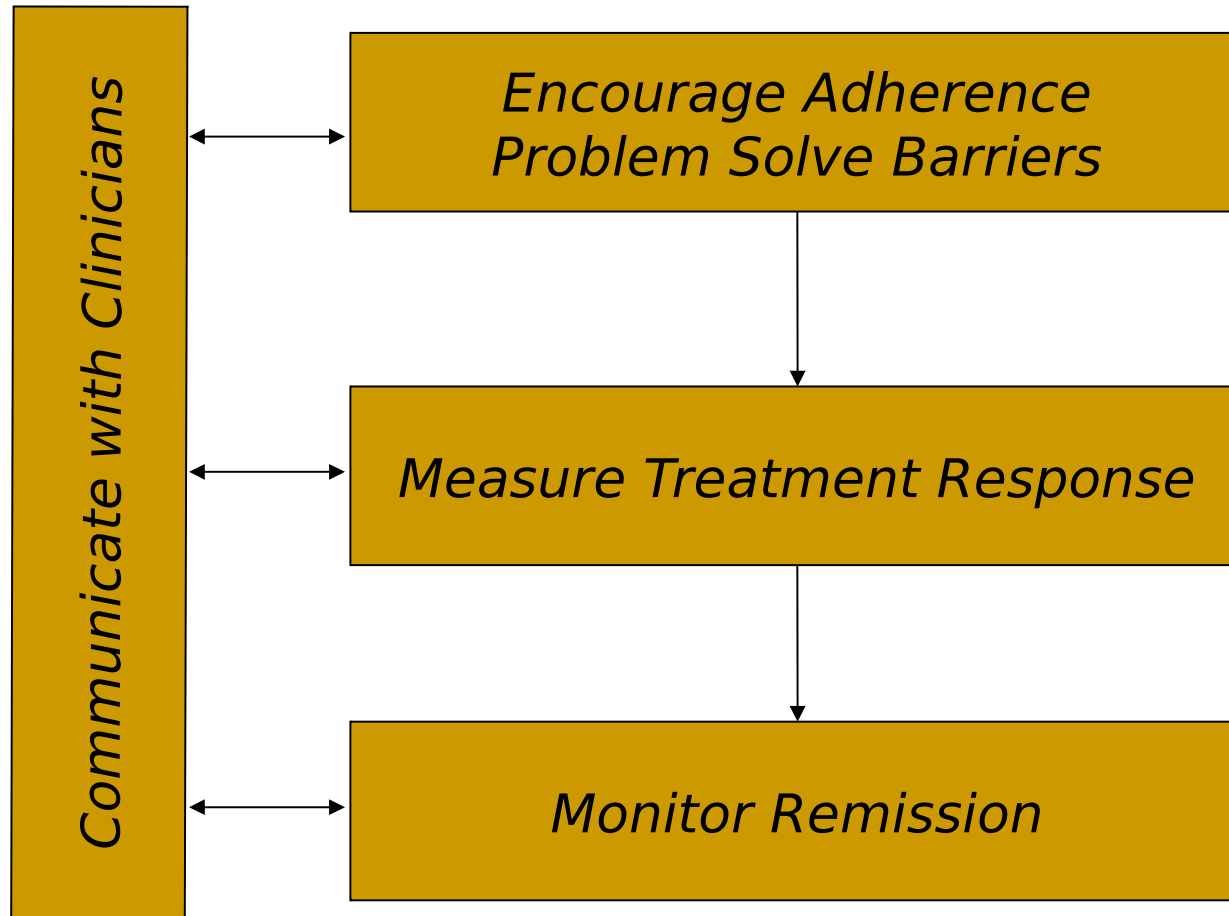


# 3 Component Model systems based care



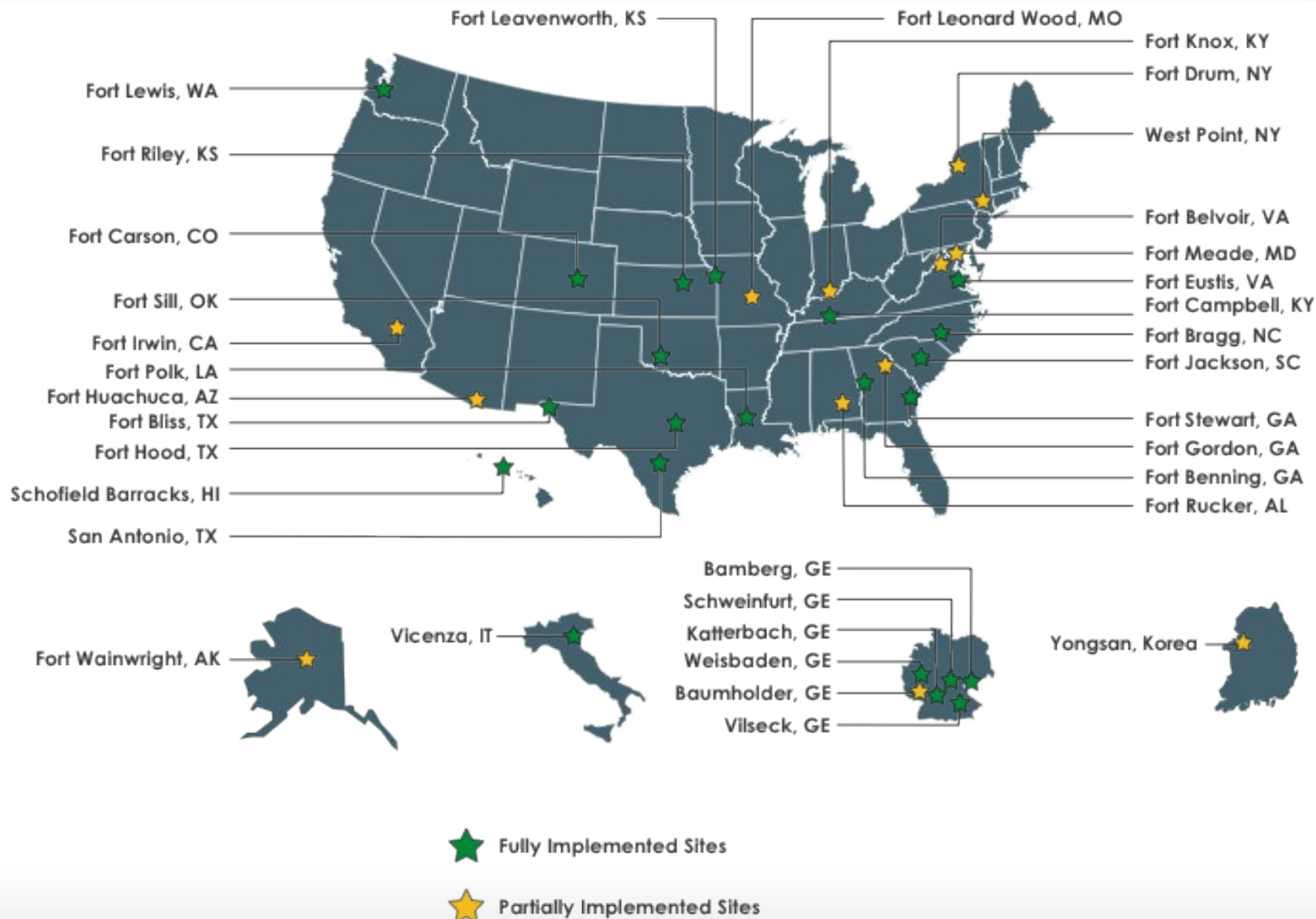
# RESPECT-Mil

## Care Facilitator Functions





# RESPECT-FMH Worldwide Sites



# Levels of Implementation



- Micro: Clinic level implementation
- Meso: Site level implementation (R-SIT)
- Macro: Program level implementation (R-MIT)

# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

# RESPECT-Mil Implementation

## Micro- or Clinic-level



- **Brief PTSD & depression screening (all visits)**
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload



# MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING

For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: \_\_\_\_\_

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen. Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

## PATIENT HEALTH QUESTIONNAIRE

### SECTION I (Check all that apply):

Over the LAST 2 WEEKS, have you been bothered by any of the following problems?

- |   |  |
|---|--|
| 1. Feeling down, depressed, or hopeless.        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Little interest or pleasure in doing things. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### SECTION II (Check all that apply):

Have you had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH, you...

- |  |  |
|--|--|
| 3. Had any nightmares about it or thought about it when you did not want to?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Were constantly on guard, watchful, or easily startled?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Felt numb or detached from others, activities, or your surroundings?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### FOR OFFICIAL USE ONLY

### PATIENT'S HEALTH QUESTIONNAIRE (Additional Comments):

Provider please reference section and question number when entering additional comments from patient.  
Please sign and date entry.

# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- **Pre-clinician diagnostic aid**
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

# PTSD Instrument (PCL-C)

2011 MHS Con



PCL							
Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully circle the number in the box which indicates how much you have been bothered by that problem <u>in the last month</u> . Please answer all 19 questions.							
	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry outbursts?	0	1	2	3	4
	15	Having difficulty concentrating?	0	1	2	3	4
	16	Being "super alert" or watchful on guard?	0	1	2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
For Primary Care Provider - Subtotal			0	+	+	+	+
			Total = _____				
18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____Not difficult    _____Somewhat difficult    _____Very difficult    _____Extremely difficult						
19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way?    _____Yes    _____No If "Yes", how often?    _____Several days    _____More than half the days    _____Almost everyday						



# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- **Patient education materials**
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload



## Participant Education & Self-Management Materials

### HOW CAN YOU IMPROVE YOUR SLEEP?

Sleep problems are common for those with PTSD. Changing your sleep pattern can take at least six to eight weeks.

Here are some areas where you may improve your sleep.

**Avoid Caffeine:** Caffeine is a stimulant found in items such as coffee, tea, soda, and chocolate, as well as in many over-the-counter medications. Those with insomnia are often sensitive to mild stimulants, and should avoid caffeine six to eight hours before bedtime. You may want to consider a trial period of avoiding caffeine altogether.

**Avoid Nicotine:** Some smokers claim smoking helps them to relax, but nicotine is actually a stimulant. Relaxing effects may occur when nicotine first enters the system, but as it builds up, it produces an effect similar to caffeine. Avoid smoking, dipping, or chewing tobacco before bedtime, and don't smoke to get yourself back to sleep.

**Avoid Alcohol:** Alcohol is a depressant. While it might help you fall asleep, as alcohol is metabolized, your sleep can become more disturbed and fragmented. Avoid alcohol after dinner, and limit its use to small or moderate quantities.

**Cautiously Use Sleeping Pills:** Sleep medications are effective only temporarily. If taken regularly, they lose effectiveness in about two to four weeks. Over time, sleeping pills may make sleep problems worse or lead to an insomnia "rebound." Many people, after long-term use of sleeping pills, mistakenly conclude that they need them to sleep

## Participant Brochure

### Depression and Post-Traumatic Stress Disorder (PTSD)

#### RESPECT-Mil (Re-Engineering Systems of Primary Care Treatment in the Military)



RESPECT-Mil

**RESPECT-Mil**  
A SOLDIER'S RESOURCE FOR RELIEF  
AND RECOVERY

NOT ALL WOUNDS ARE VISIBLE



RESPECT-Mil

**RESPECT-Mil**  
INFORMATION FOR SOLDIERS  
REGARDING  
DEPRESSION

### SELF-MANAGEMENT WORKSHEET

There are several things you can do to help yourself feel better, even when you're not at your best. Start by selecting one of the activities from this list. Then monitor to take it slowly at first and add new things as you begin to feel better.

#### 1. Make time for pleasurable physical activities.



Be sure to make time to concentrate on your basic physical needs. One example is walking for a certain length of time each day.

For \_\_\_\_\_ days next week, I'll spend at least \_\_\_\_\_ minutes doing \_\_\_\_\_

#### 2. Find time for pleasurable activities.



Even though you may not feel as motivated or happy as you used to, commit to scheduling a fun activity (such as a favorite hobby) at least a few times a week.

For \_\_\_\_\_ days next week, I'll spend at least \_\_\_\_\_ minutes doing \_\_\_\_\_ (Be sure to make your goal both easy and reasonable.)

#### 3. Spend time with people who can support you.



It's easy to feel isolated when you're feeling down. But, it's times like these that you need the support of friends and family. If you can, explain to them what you are going through. If you don't feel comfortable talking about it, that's all right. Just asking them to be with you, maybe during one of your walks, is a good first step. Suggestions include: meeting a friend for coffee, going shopping with a friend, playing cards or taking a walk with a neighbor, working with a group in the garden – anything that is social and enjoyable.

During the next week, I'll make contact at least \_\_\_\_\_ times with \_\_\_\_\_ (name / doing/ talking about \_\_\_\_\_)

#### 4. Practice relaxing.



For many people, the changes that come with depression or PTSD can lead to anxiety. Slow physical activity can lead to mental relaxation, peace in taking in another way. Try deep breathing, taking a warm bath, or just finding a quiet, comfortable, peaceful place. Place comforting things to you as well.

For \_\_\_\_\_ days next week, I'll practice physical relaxation at least \_\_\_\_\_ times, for at least \_\_\_\_\_ minutes each time. (Be sure to make your goal easy and reasonable.)

#### 5. Simple goals and small steps.



It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others can't. It can be hard to deal with them when you're feeling sad, but it's the only way to deal with them. Start with small steps. Try breaking down large problems into smaller steps and then take one small step at a time. Give yourself credit for each step you accomplish.

The problem is: \_\_\_\_\_

My goal is: \_\_\_\_\_

Step 1: \_\_\_\_\_

Step 2: \_\_\_\_\_

Step 3: \_\_\_\_\_

#### 6. Eat nutritious, balanced meals.



You are what you eat. Many people find that when they eat more nutritious, balanced meals, they feel only a little better physically, they feel better emotionally and mentally also.

During the next week, I will improve my diet by: \_\_\_\_\_

Example: "Drink more." Eat at least two fruits and vegetables a day.

#### 7. Avoid or minimize alcohol use.



Alcohol is a depressant and can add to feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.

I will restrict my alcohol intake to no more than two drinks on no more than two days per week.

## Goals & Self-Management Worksheet

### RESPECT-Mil Depression Management Using the PHQ-9 (0 - 27 point scale)

#### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
1. Over the last 2 weeks, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling or staying asleep or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure...or guilty	0	1	2	3
g. Trouble concentrating on things, such as reading, doing work, or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – so fast that you were embarrassing yourself?	0	1	2	3
i. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total Score				
add columns:				
Not Difficult		Some-what Difficult	Very Difficult	Extremely Difficult

PHQ-9 Copyright © 1997 by the Medical Outcomes Trust. Reproduced in compliance with copyright policies. <http://www.phq-questionnaire.com/terms.aspx>

\*If symptoms persist, see your primary care doctor, depression specialist, or mental health professional. \*\*If symptoms persist, see your primary care doctor, depression specialist, or mental health professional. \*\*\*If symptoms persist, see your primary care doctor, depression specialist, or mental health professional.

#### DEPRESSION PROVISIONAL DIAGNOSIS & TREATMENT RECOMMENDATIONS

PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
0-4	No Depression	N/A
5-9	Minimal Symptoms*	Support, educate to call if worse; return in one month.
10-14	Minor Depression+ Mild Dysphoria*	Support, watchful waiting. Antidepressant or counseling. Antidepressant or counseling.
15-19	Major Depression, Moderately Severe	Antidepressant or counseling.
20-27	Major Depression, Severe	Antidepressant and counseling.

#### Initial Response to an Adequate Dose of Antidepressant After Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of 5+ points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably Inadequate	Probably warrants an increase in dose.
Drop of 1-2 points or no change or increase	Inadequate	Increase dose; switch drugs; augmentation; individual or formal psychiatric consultation; Add counseling.

#### Initial Response to Counseling After Four Sessions over Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of 5+ points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3-4 points from baseline	Probably Inadequate	Possibly no treatment change needed. Share PHQ-9 with the provider.
Drop of 1-2 points or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, PBT, IPT, etc.) is not available, consider adding antidepressant.

For patients unresponsive to other types of psychological counseling, consider starting antidepressant. For patients identified in other type of counseling, review treatment options and preferences.

## Provider "Fast Facts"

# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- **Psychosocial options**
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

# DESTRESS-PC



- **DE**livery of
- **S**elf-
- **TR**aining &
- **E**ducation for
- **S**tressful
- **S**ituations –
- **P**rimary **C**are version

*Web-based, nurse assisted, CBT-based PTSD self-training*

2011 MHS Conference

## Article

### A Randomized, Controlled Proof-of-Concept Trial of an Internet-Based, Therapist-Assisted Self-Management Treatment for Posttraumatic Stress Disorder

Brett T. Litz, Ph.D.

Charles C. Engel, M.D., M.P.H.

Richard Bryant, Ph.D.

Anthony Papa, Ph.D.

**Objective:** The authors report an 8-week, randomized, controlled proof-of-concept trial of a new therapist-assisted, Internet-based, self-management cognitive behavior therapy versus Internet-based supportive counseling for posttraumatic stress disorder (PTSD).

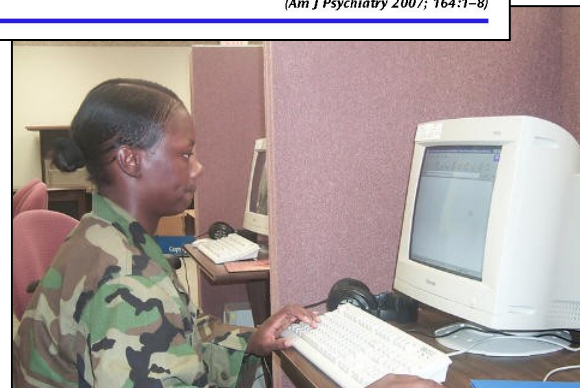
**Method:** Service members with PTSD from the attack on the Pentagon on September 11th or the Iraq War were randomly assigned to self-management cognitive behavior therapy (N=24) or supportive counseling (N=21).

**Results:** The dropout rate was similar to regular cognitive behavior therapy (30%) and unrelated to treatment arm. In the

intent-to-treat group, self-management cognitive behavior therapy led to sharper declines in daily log-on ratings of PTSD symptoms and global depression. In the completer group, self-management cognitive behavior therapy led to greater reductions in PTSD, depression, and anxiety scores at 6 months. One-third of those who completed self-management cognitive behavior therapy achieved high-end state functioning at 6 months.

**Conclusions:** Self-management cognitive behavior therapy may be a way of delivering effective treatment to large numbers with unmet needs and barriers to care.

*(Am J Psychiatry 2007; 164:1-8)*



# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- **Care Facilitator assisted follow-up option**
- **Aggressive facilitator outreach & monitoring**
- **Web-based care facilitation system**
- “Just-in-time” treatment adjustment
- Weekly BH Champion review of facilitator caseload

# FIRST-STEPS

## Web-based Care-Manager Support & Reporting System

**Medication Management**

Medication saved.

New Entry

Medication:  Save

Dose:  mg.

Prescribe Date:

Change Date:

Change Type:

Comments:

View Entries:

Archive?	Medication	Dose	Prescribe Date	Change Date	Change Type	Comments	Entered By	Error?
<input type="checkbox"/>	Ambien® (zolpidem)	50	10/15/2008	10/18/2008	Start Med	Todd Musig (30 Oct 08)		<input type="checkbox"/>

**Summary/Estimate**

FINAL ESTIMATE FOR: Jane Smith

The final estimate has NOT been made for this snapshot

You made the following estimates:

Category	First	Previous	Current
General Concern	Moderate	Low	Low
Medication Non-Adherence	High	High	Moderate
Counseling Non-Adherence	High	Moderate	Low
Self Management Concern	Low	Moderate	High
PCL	33-68	13-32	13-32
Suicide Staffing	A Week	A Week	NA
Case Status	Flagged	No Flag	No Flag

Based on the information obtained from the above Factor Groups, please rate the level of concern you have for this patient.

Low Moderate High

**Historical Graphs**

Historical Graph for: PHQ-9

# RESPECT-Mil Implementation

## Micro- or Clinic-level



- Brief PTSD & depression screening (all visits)
- Pre-clinician diagnostic aid
- Patient education materials
- Psychosocial options
- Care Facilitator assisted follow-up option
- Aggressive facilitator outreach & monitoring
- Web-based care facilitation system
- **“Just-in-time” treatment adjustment**
- **Weekly BH Champion review of facilitator caseload**



# FIRST-STEPS

Improves Efficiency, Accountability & Effectiveness of Facilitator Staffing



home	resources	contact	help	logout	PDRMS		
Select Individual >	Open/Recent PREs	ABCDEFGHIJKLMNOPQRSTUVWXYZ ALL				Search	New Individual
<b>Acuity</b>		IMPORTANT MESSAGE			MESSAGE FROM PREVIDENCE		
		Welcome.			Welcome to the Providence Risk <a href="#">more</a>		
Acuity	Case Closure	Call Schedule	Caseload	Closed Cases			
<a href="#">MY VIEW</a>   UNIT VIEW						<a href="#">Print Preview</a>	
<u>Unit</u>	<u>Name</u>	<u>Suicide Staffing</u>	<u>Facilitator Concern</u>	<u>Deployers</u>	<u>Tx Non-Response</u>	<u>Last Staffing Date</u>	<u>Last Contact</u>
Fort Hood	<a href="#">April, Test</a>	Unknown	Moderate	30-60 Days	No		25 Apr 08
Germany 1	<a href="#">Braxton, Bruce</a>	Emergency	High		No		12 Aug 08
Beta Fort Stewart	<a href="#">Frankie, Bill</a>	A Duty Day	High	60-90 Days	No	2 Oct 08	2 Oct 08
Beta Fort Bliss	<a href="#">Harry, Dirty</a>	A Duty Day	High	Not Deploying	No		20 Oct 08
Fort Drum	<a href="#">New, Tom</a>	A Duty Day	Unknown		No		24 Apr 07
Fort Carson	<a href="#">Turner, Bill</a>	A Duty Day	Unknown		No		20 Apr 07
Vicenza	<a href="#">Violet, Eric</a>	A Duty Day	Unknown		No		19 Apr 07
Fort Lewis	<a href="#">Wilking, Sarah</a>	A Duty Day	Unknown		No		19 Apr 07

# RESPECT-Mil Implementation

## Macro- or Program-level



### RESPECT-Mil Implementation Team (R-MIT):

- Monitors program implementation, fidelity, outcomes
- Trains & consults with R-SiTs
- Develops & disseminates education modules and tools
- Pilots & evaluates new components
- Performs site visits & site calls



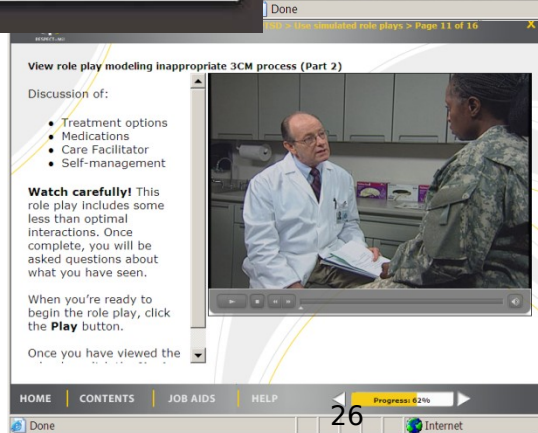
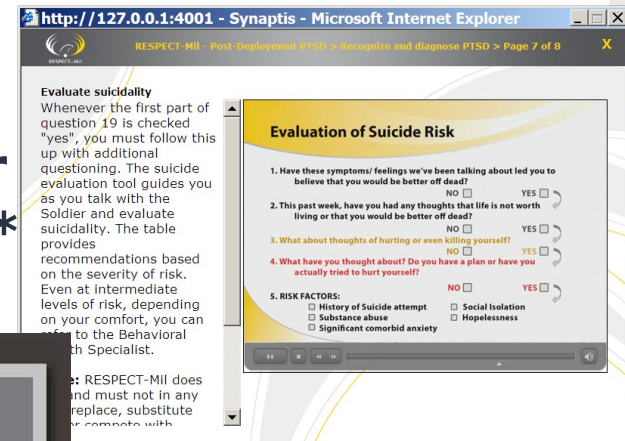
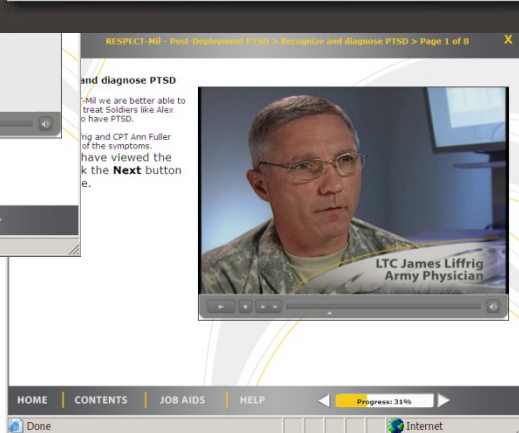
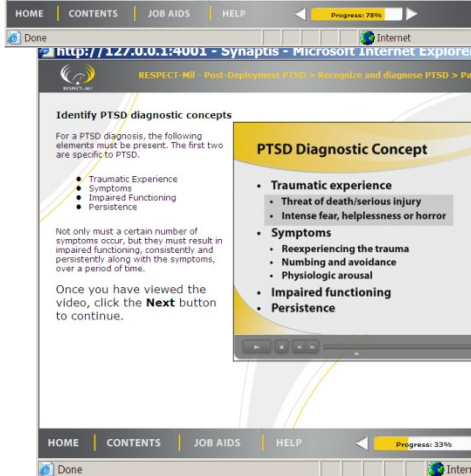
# RESPECT-Mil Implementation

## Meso- or Site-level



- RESPECT-Mil Site Team (R-SIT)
- Primary Care Champion
  - Monitors local program & process
- Behavioral Health Champion
  - Monitors facilitator caseloads
- Facilitator
  - RN, 1 per 6K in eligible population
- Administrative assistant
  - 1 per 10K in eligible population

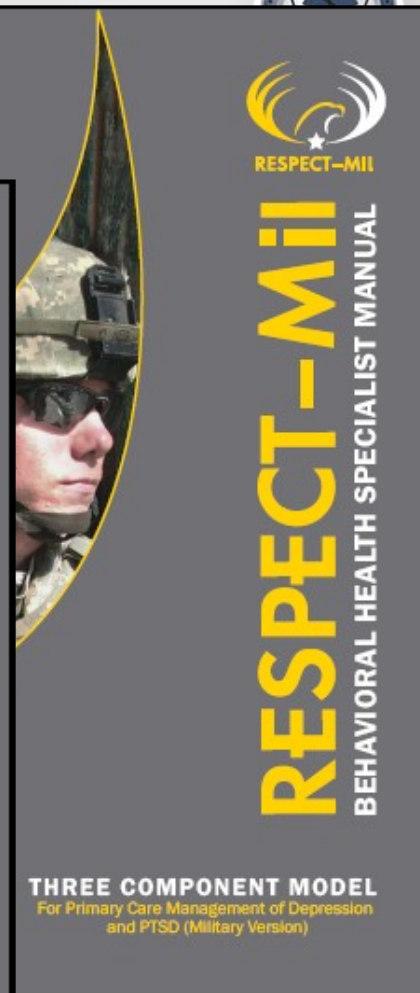
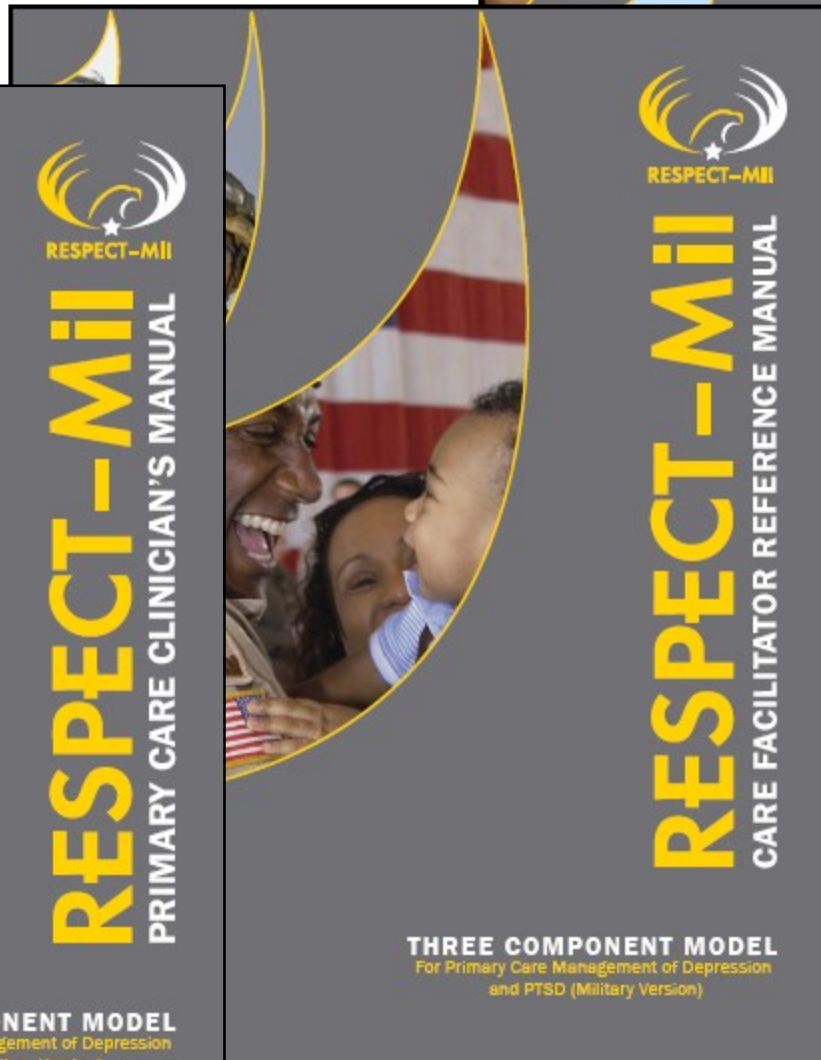
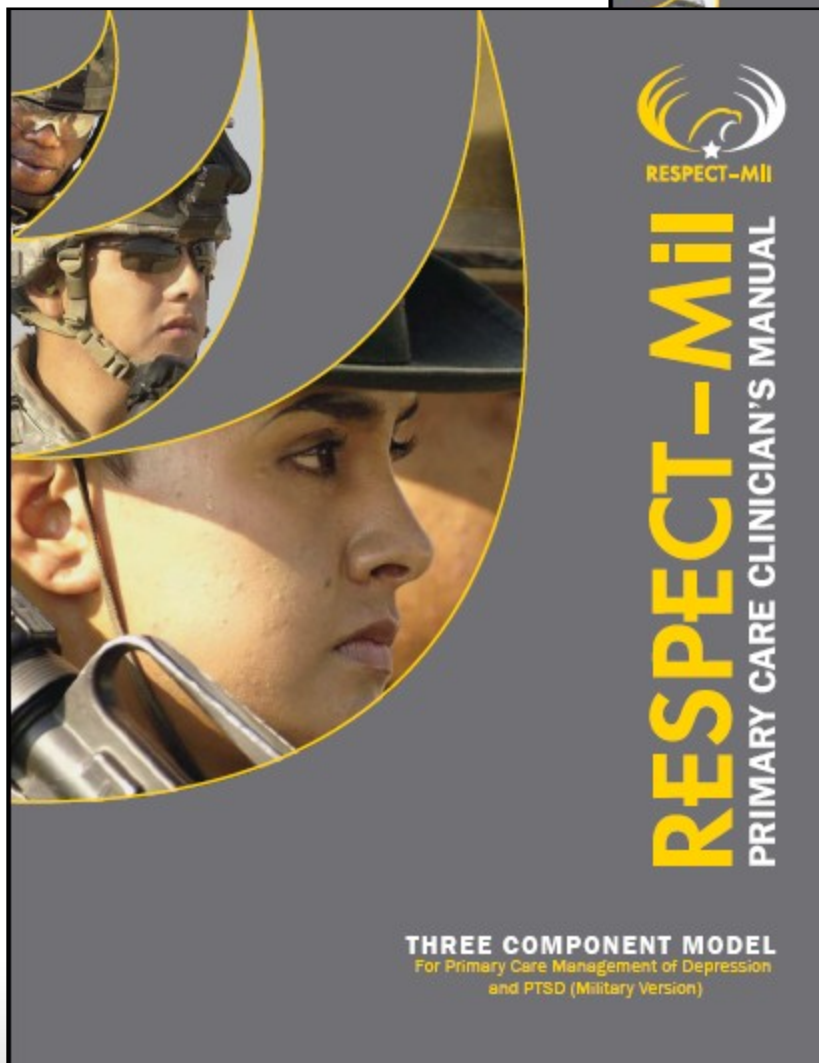
# Web-Based PTSD & Depression Training for Primary Care Providers\*



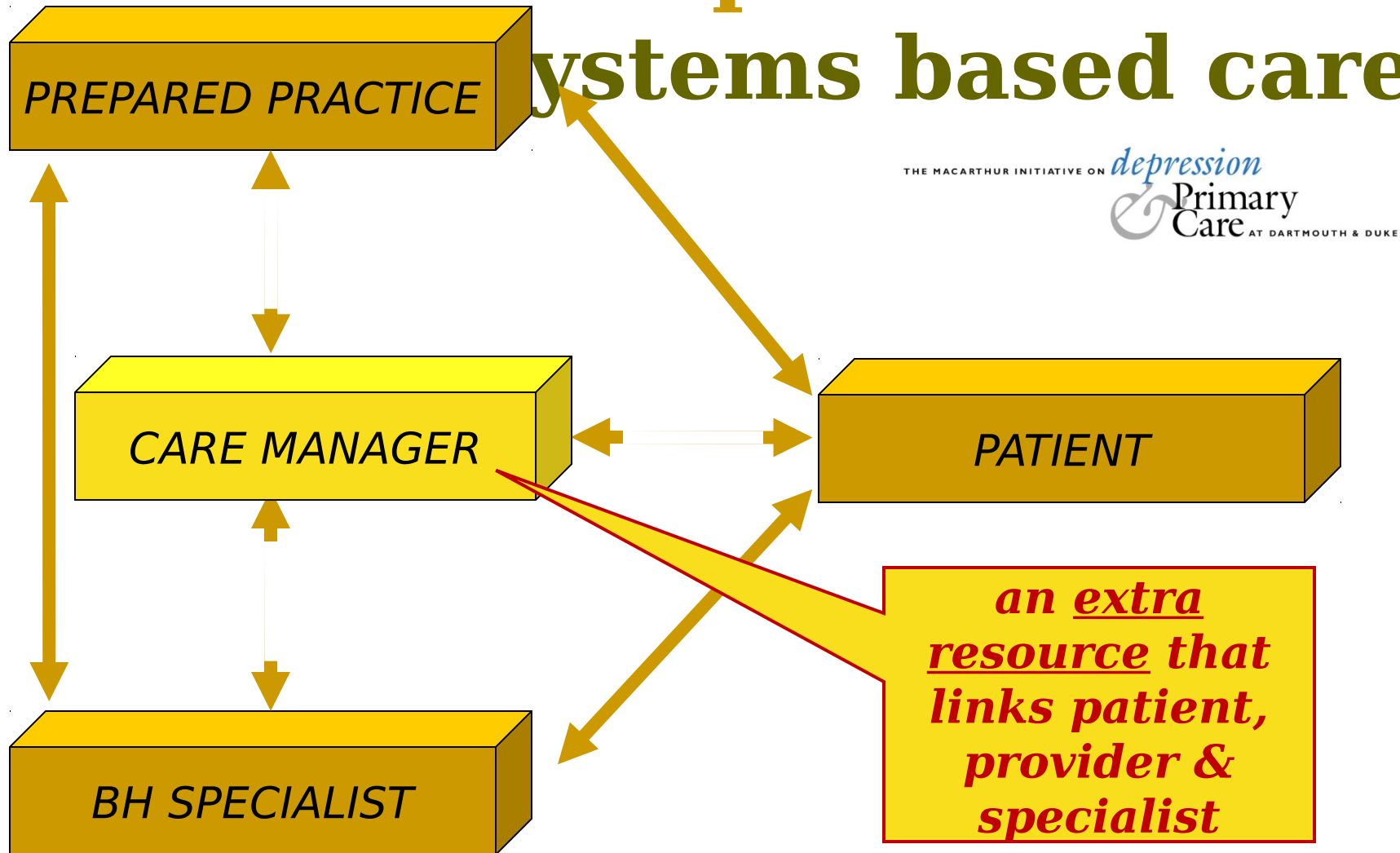
\* Includes suicide assessment training

# RESPECT-Mil

## *Provider Manuals*



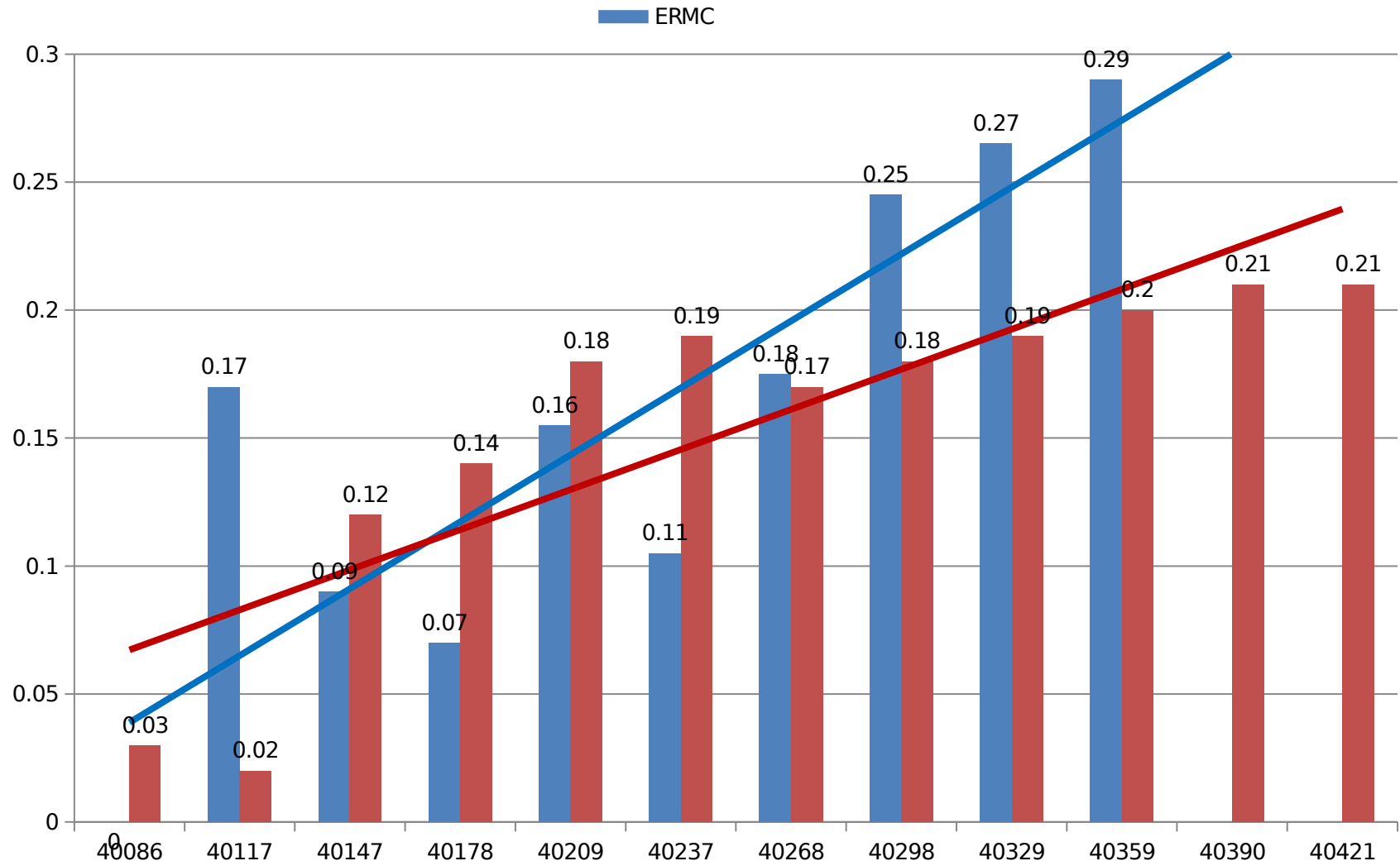
# 3 Component Model systems based care





# Real-time Aggregate Data Reports

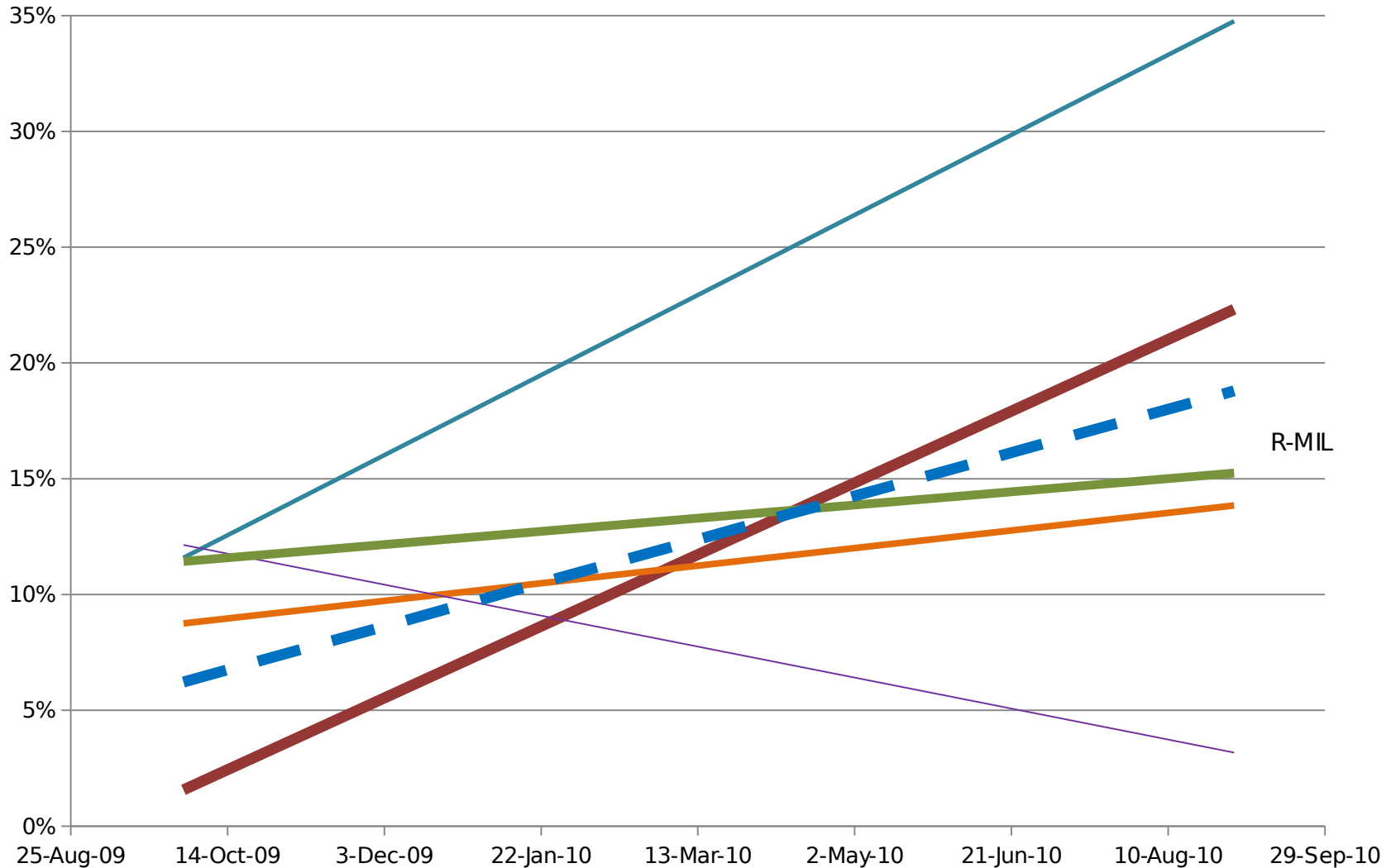
## Region PTSD Remission Trend



\*\*Remission is defined as the count of individuals who have an open episode in FIRST STEPS, have been in the system 8 weeks or more, and have a PCL score of 10 or less.

# Real-time Aggregate Data Reports

## PTSD Remission Trends by Region



# RESPECT-Mil

## Implementation Results

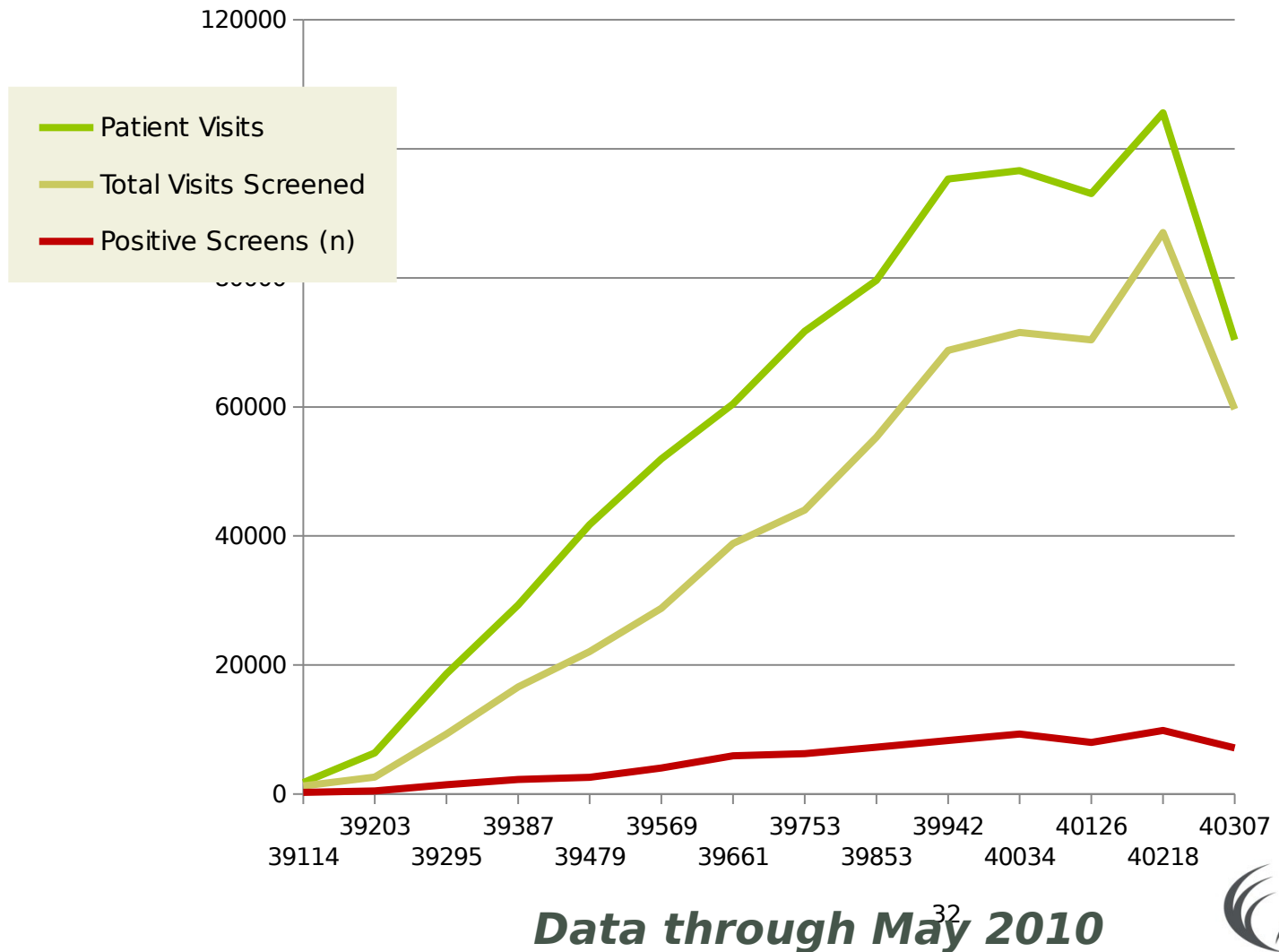


- **55** clinics now implementing (95 projected)
- **84%** of visits screened (versus 2-5% in non-RESPECT-Mil teaching clinic)
- **13%** of all screened visits are positive
- **48%** of positive screens result in a diagnosis of 'depression' or 'possible PTSD'

*\* Data through November 2010*

# Visits

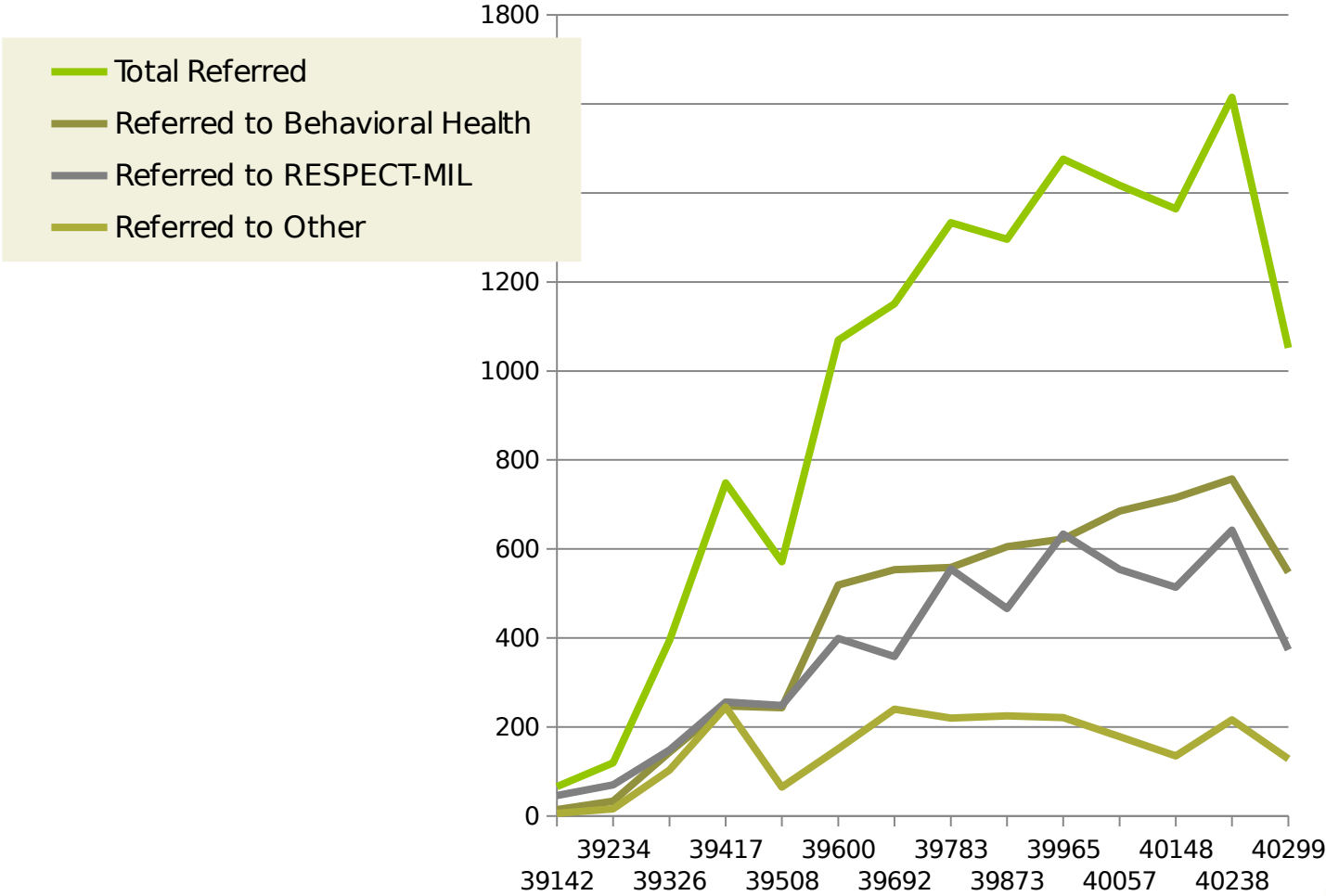
**\*Consistently Rising Rate of Program Implementation\***





# Services

**\*Referrals for Facilitation Nearly as High as to Specialist\***

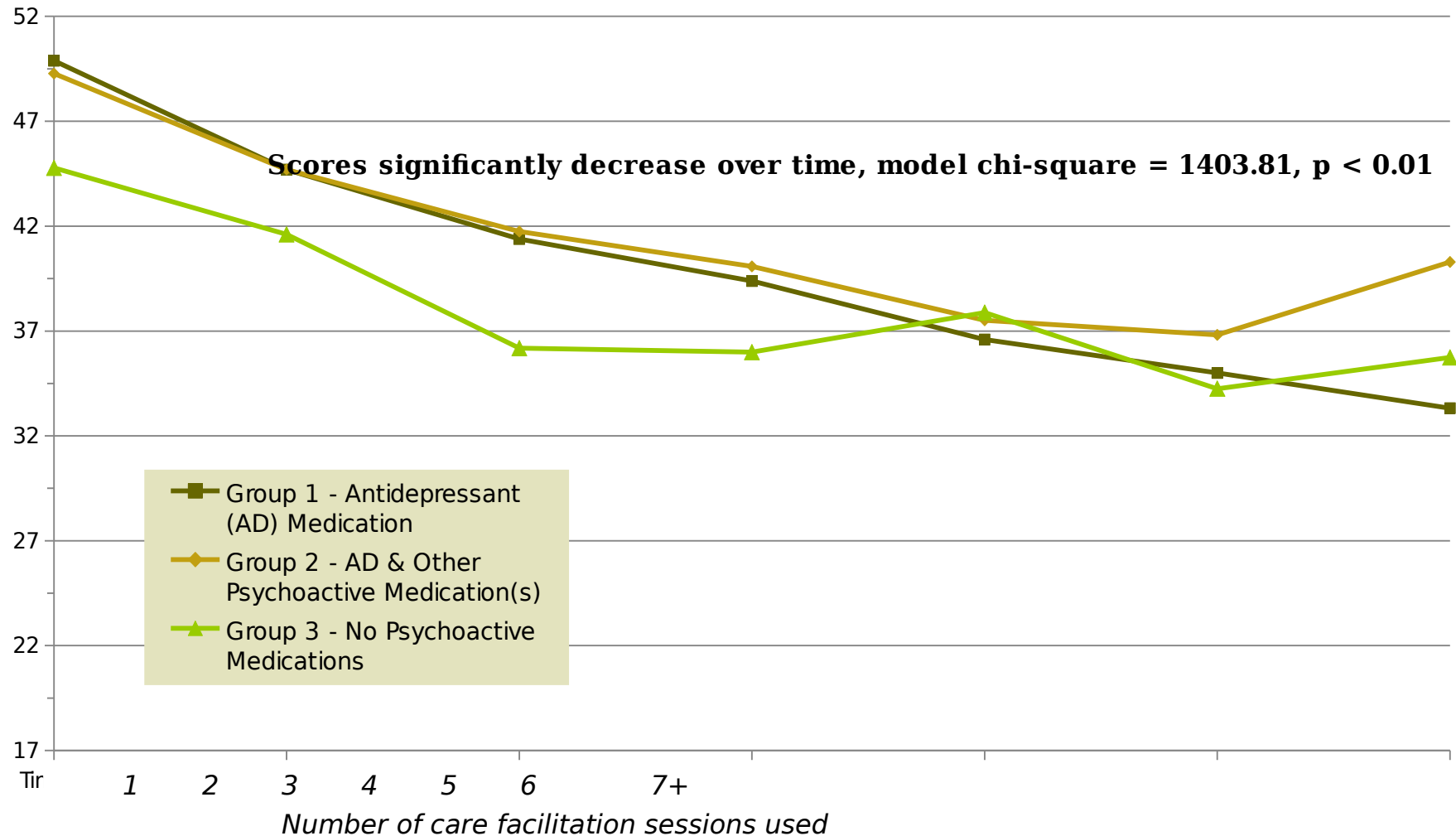


**\* Data through May 2010**



# (PCL-C)

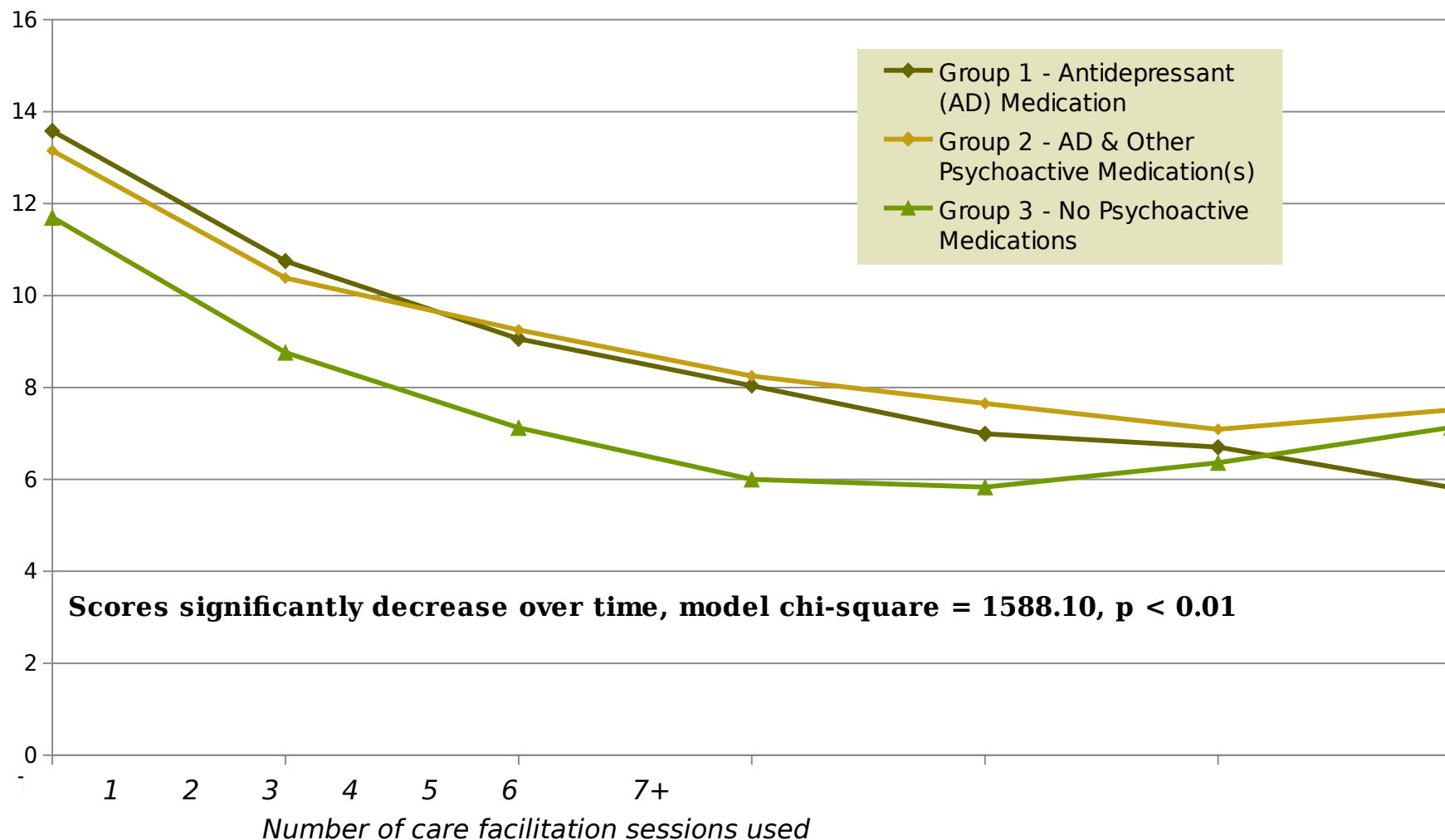
## \*Number of facilitator visits associated with improvement\*



\* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)

# Severity (PHQ-9)

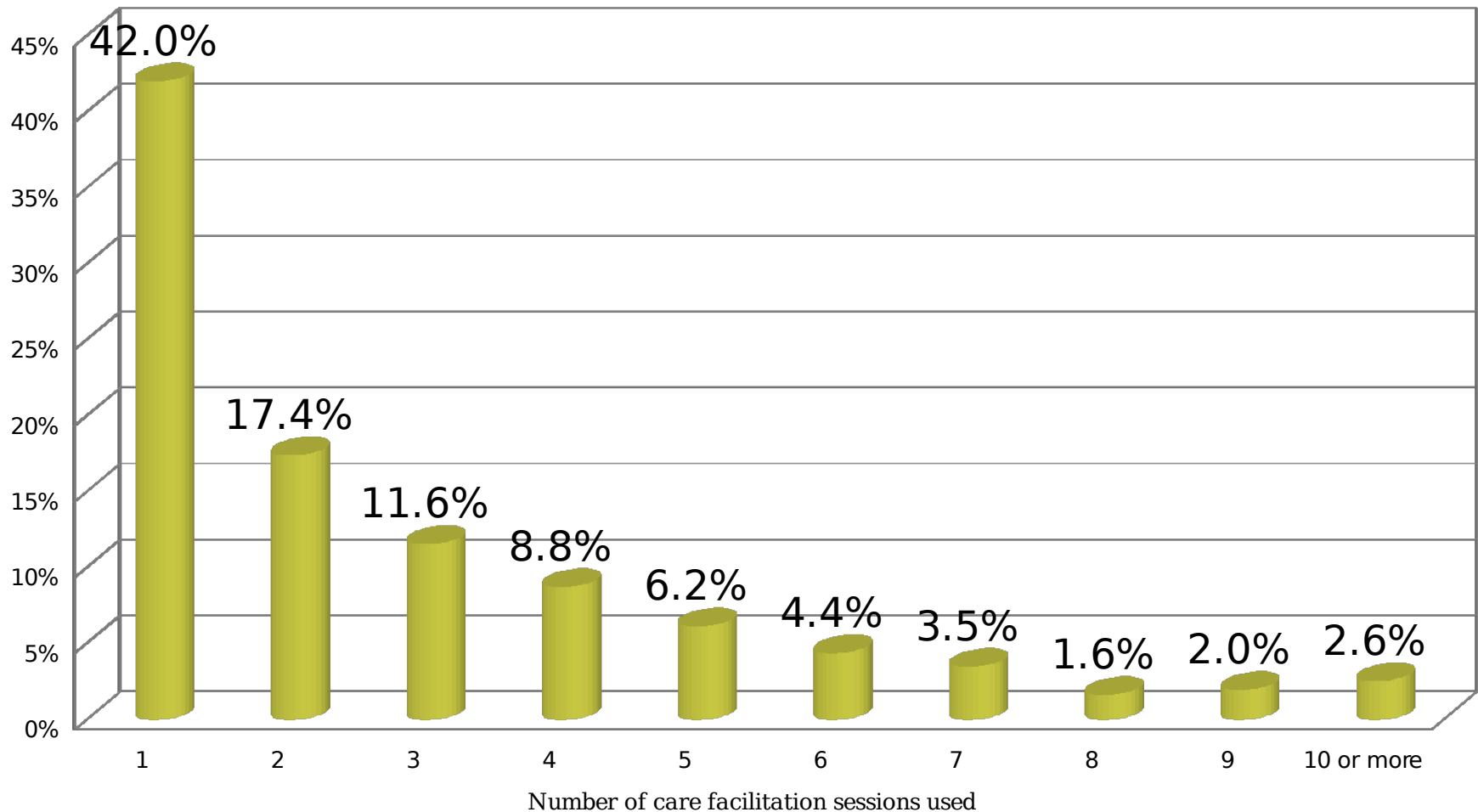
**\*Number of facilitator visits associated with improvement\***



**\* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to 31 Aug 2009 (N = 2,548)**

# RESPECT-Mil Facilitator Use

**\*Only 20.6% have four or more facilitator contacts\***



\* Data from RESPECT-Mil enrolled cases from 01 Feb 2007 to <sup>36</sup>31 Aug 2009 (N = 2,548)

# RESPECT-MiI

## Safety & Risk Management



- Visits associated with any suicidal ideation
- 1% of screened visits (7.6% of screen positive visits)
- 27% of visits involving suicidal ideation are rated by provider as intermediate or high risk (“non-low risk”)
- Frequent “save” anecdotes

**\* Data through Nov 2010**

# RESPECT-MiI

## Safety & Risk Management



- Visits associated with any suicidal ideation
- Appropriate risk assessment
  - 99.4% of screened positive visits
- Appropriate risk assessment
  - 99.9% of screened visits

**\* *Data through May2010***



**66% assistance rate**  
accept/[accept + decline]

**3% of all visits**  
involve recognition & assistance for  
previously unrecognized mental health  
needs

*\* Data through Nov 2010*



# RESPECT-Mil

## Findings to Date



- Often concerns about getting started
- Once started, approach is acceptable and feasible for both Soldiers and providers
- Enrolled soldiers show clinical improvement
- Identifying & referring Soldiers with previously unrecognized and unmet needs
- Enhanced safety and risk assessment capabilities

# RESPECT-Mil

## Challenges & Road Ahead



- Intercalation with **Patient Centered Medical Home**
- Web-based training ongoing  
<http://www.pdhealth.mil/respect-mil.asp>
- **FIRST-STEPS** performance reporting
- **Alcohol SBIRT** demonstration in preparation
- **REHIP** triservice demonstration of a “blended” model
- **STEPS-UP Trial** – a 5-year, 18-clinic controlled trial (n=1500) intervention is blended + centralized care management + stepped psychosocial modalities

# RESPECT-MiI

## Review of Findings to Date



- Often concerns about getting started; once started the approach is feasible and acceptable
- Identifying & referring patients with previously unrecognized and unmet needs
- Clinical improvement is related to use of care facilitation
- Only ~20% reach 4 facilitator visits (~5 months)
- Most sites lack accessible evidence-based psychosocial therapies

# RESPECT-Mil Central

## Implementation Team

**COL Charles Engel, MC**  
Director

**Tim McCarthy**  
Deputy Director

**Sheila Barry, BA**  
Associate Director,  
Development & Training

Program

**Mark Weis, MD**  
Primary Care Health Proponent

**David Dobson, MD**  
Behavioral Health Proponent

**Kelly Williams, RN**  
Nurse Proponent & Educator

**Lee Baliton**  
Program Evaluation/IT Specialist

**James Harris**  
Program Manager

**Justin Curry, PhD**  
Associate Director, Program Evaluation

**Barbara Charles**  
Administrative Assistant

**Phyllis Hardy**  
Administrative Assistant

## Consultant Team

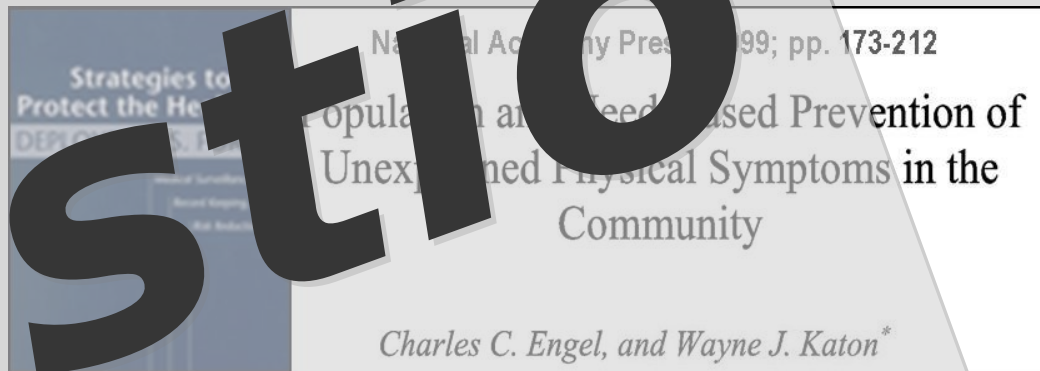
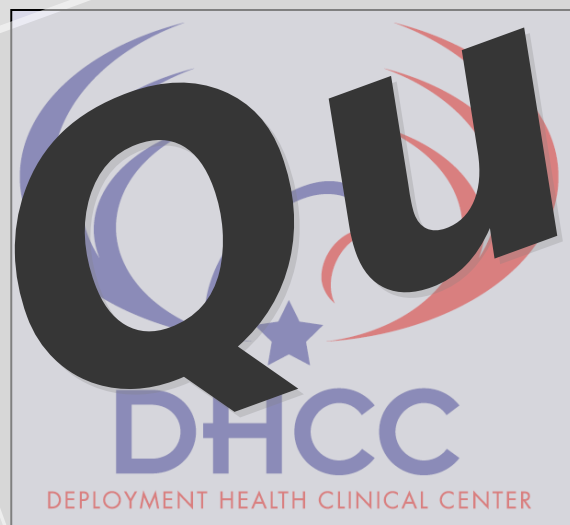
**Allen Dietrich, MD**  
Professor of Family Medicine, Dartmouth  
Medical School

**Thomas Oxman, MD**  
Emeritus Professor of Psychiatry, Dartmouth  
Medical School

**John Williams, MD, MSPH**  
Professor of Medicine, Duke University &  
Durham VA

**Kurt Kroenke, MD**  
Professor of Medicine, Indiana University &  
Regenstrief Institute





PROCEEDINGS  
OF  
THE ROYAL  
SOCIETY

Phil. Trans. R. Soc. B (2006) 361, 707–720  
doi:10.1098/rstb.2006.1829  
Published online 24 March 2006

## Managing future Gulf War Syndromes: international lessons and new models of care

Charles C. Engel<sup>1,2,\*</sup>, Kenneth C. Hyams<sup>3</sup> and Ken Scott<sup>4</sup>

## Can We Prevent a Second Gulf War Syndrome? Population-Based Healthcare for Chronic Idiopathic Pain and Fatigue after War<sup>1</sup>

Charles C. Engel<sup>a,b</sup>, Ambereen Jaffer<sup>b</sup>, Joyce Adkins<sup>b</sup>, James R. Riddle<sup>c</sup>, Roger Gibson<sup>d</sup>

## Population-based health care: A model for restoring community health and productivity following terrorist attack

Charles C. Engel, Ambereen Jaffer, Joyce Adkins, Vivian Sheliga, David Cowan, and Wayne J. Katon

## Terrorism and Disaster

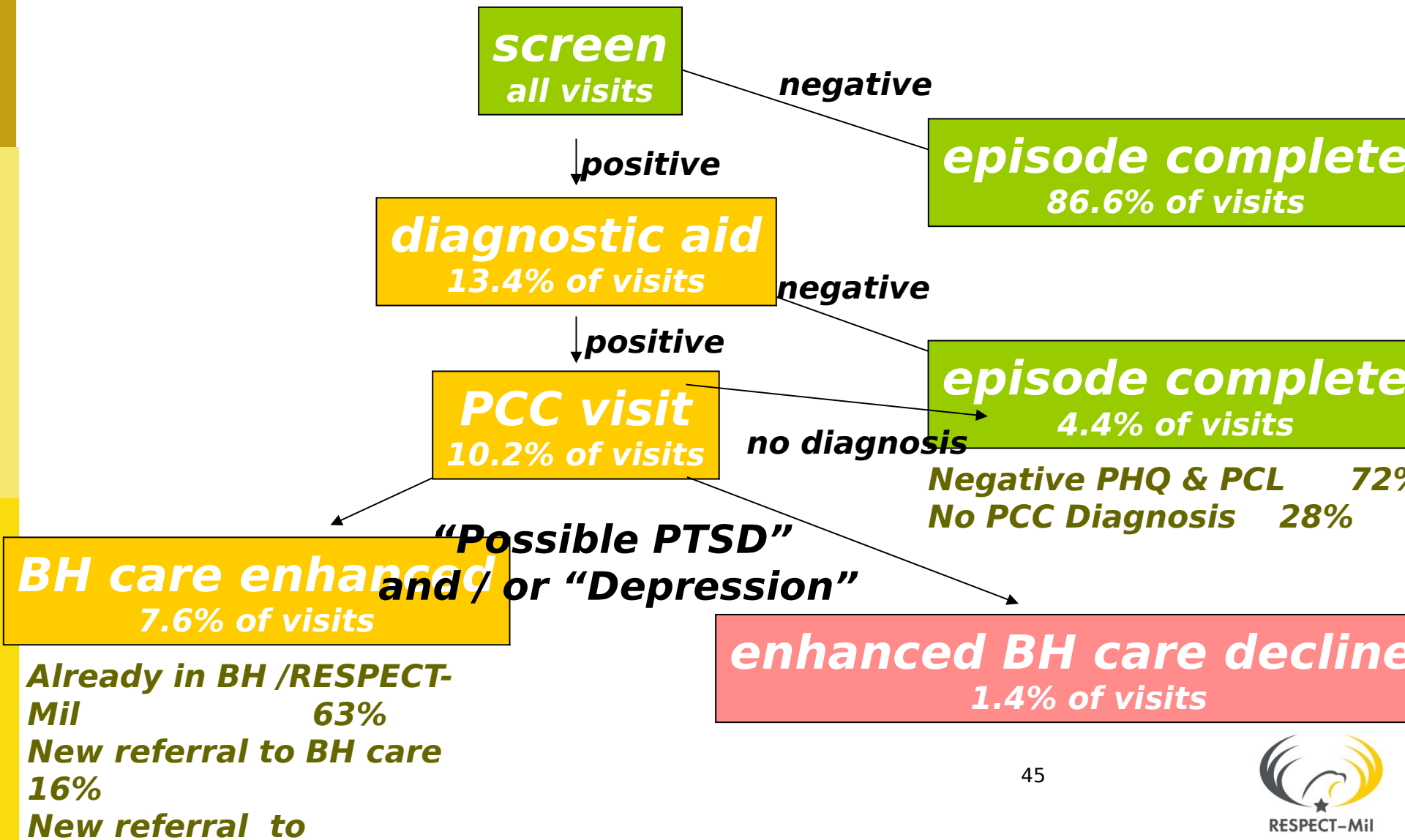
Individual and Community Mental Health Interventions

Robert J. Ursano

Carol S. Fullerton

Ann E. Norwood

# Patient Flow & Clinic Process



# RESPECT-Mil

Time & Workload

component %  
visits

estimated time /  
visit

**All clinic patients**  
**100.0%**

**2 minutes medic**  
**time**

**Screen positive**  
**13.4%**

**3 minutes medic**  
**time**

**Diagnosis 10.2%**

**10 minutes clinician**  
**time**

**Suicidality 0.7%**

**25 minutes clinician**  
**time**

**Total Estimated Time**  
**Visit**

**Medic = 2 + (0.134 x 3)**

**min**

**vider**

**(0.102**

**x 10) + (0.007 x 25)**



# RESPECT-Mil

## Creating Efficiencies

~ **90%** of visits require **NO** added provider **time**

~ **84%** of added clinician time is for the **0.7%** of visits at highest risk

